Journal of Forensic and Legal Medicine 17 (2010) 194–197

Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/jflm

Original Communication

Training of Assistant Forensic Medical Examiners in London, UK

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ARTICLE INFO

Article history:
Received 19 December 2009
Accepted 22 December 2009
Available online 22 January 2010

Keywords:
Forensic physician
Forensic medical examiner
Clinical forensic medicine
Clinical supervisor
Educational supervisor

ABSTRACT

The overall aim of this pilot study was to evaluate the quality of current practical training in London with a view to improving future training as part of faculty development.

New trainees in clinical forensic medicine (CFM), Assistant Forensic Medical Examiners (AFMEs), were interviewed to gather their views of their recent training experience and to attempt to identify problems with implementing the training as it stands.

An overwhelming theme emerged that there should be a more formal structure to the training of newly appointed FMEs. Each trainee should have a named clinical and educational supervisor during the training period. Furthermore it should be mandatory for educational supervisors to undergo training and review of performance.

1. Background

Doctors training and practicing in the field of clinical forensic medicine (CFM) in London, UK, are working in the independent sector, outside the formal regulation of the National Health Service (NHS). Currently forensic and legal medicine is not recognised as a speciality in the UK. However, good practice suggests that any training programme should be at least as good as that available for doctors working within the NHS. The General Medical Council is clear that doctors should recognise and work within the limits of their competence and keep their knowledge and skills up-to-date being familiar with relevant guidelines.[1]

In July 2008, the Postgraduate Medical Education and Training Board issued guidance on the standards that must be applied when postgraduate medical education and training takes place.[2] This stipulates that trainers must provide a level of supervision appropriate to the competence and experience of the trainee and those trainees should have sufficient practical experience with accessible supervision and regular feedback.

The reference guide for speciality training in the UK, the 'Gold Guide',[3] provides guidance to postgraduate deans and covers all speciality training, including general practice. The Gold Guide requires that each trainee should have a named clinical supervisor for each placement, usually a senior doctor, who is responsible for ensuring that appropriate clinical supervision of the trainee's day-to-day clinical performance occurs at all times, with regular feedback.

For some years prior to January 2009, a doctor wishing to work in the Metropolitan Police area as a forensic medical examiner (FME, forensic physician, FP) shadowed an experienced doctor prior to being interviewed to ensure awareness of the type of work involved. After successful interview the doctor attended the five day theoretical training course run by the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM) and the National Policing Improvement Agency (NPIA). The trainee doctor was then appointed to a group of doctors providing cover to an area in London with a Principal FME. The FFLM have produced a guide to the practical induction training in clinical forensic medicine, satisfactory completion of which leads to a 'Certificate of achievement of a standard of minimal acceptable competence in clinical forensic medicine' – the 'certificate'.[4]

The Principal FME (PFME) had a contractual requirement to supervise the 'needs and induction of' AFMEs. However research has shown that not all PFMEs have used the suggested FFLM programme of training and the methods by which PFMEs ensured that AFMEs were competent to work in police stations varied.[5]

At the end of two years' supervision, PFMEs are asked whether the AFMEs are 'suitable to be issued with an FME contract'. It was also recommended that an assessment by an independent senior FP should be carried out. This involved an interview where the doctor's original notes, statements and other relevant paperwork were examined by the senior FP, who would then advise the police on the doctor's suitability for progression to the post of FME.

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doi:10.1016/j.jflm.2009.12.010

In January 2009, the MPS introduced a new contract for FMEs that removed the post of PFME and did away with the group structure under which FMEs had previously worked.

FMEs come from a variety of clinical backgrounds including, for example, general practice, emergency medicine, and psychiatry. As a consequence, AFMEs entering the specialty of clinical forensic medicine have varying qualifications and competencies and may be more or less well equipped to perform the role of an FME. Close supervision in the early days of practice is essential to support these doctors and address their differing needs.

The Postgraduate Hospital Educational Environment Measure (PHEEM) has been developed as a quality assessment tool of clinical teaching and learning for junior doctors.[6] This tool looks at perceptions of role autonomy, teaching and social support and was used to create a pro forma for the semi-structured interviews (available from MS).

It is essential in assessing any training programme to obtain the views of trainees/learners to aid future development.[7] Previous research has concluded that the level of supervision provided by supervisors is correlated with levels of stress and anxiety in junior doctors.[8] PMETB surveys trainers and trainees each year to assure the quality of postgraduate education and training.[9]

The overall aim of this study was to evaluate the quality of current practical training in London with a view to improving future training and, in particular, to assess whether the Assistant Forensic Medical Examiners (AFME) in London receive appropriate practical induction training following the theoretical training course.

The specific aims of this study were:

- To gather the views of the AFMEs' on their training experiences.
- To identify problems with implementing the training as it stands.
- To assess whether AFMEs received the 'certificate' of competence on completion of their practical induction programme.

It was hoped that recommendations could be made to the FFLM regarding standardisation of practical training programmes in the future.

2. Methodology

Training of new doctors in this field varies throughout the country, within different constabularies, and there is no central register of trainees so as a pilot project the focus for this study was London.

There are 18 PFMEs who were contacted to establish if there were any members of their group of doctors who had undergone practical training as AFMEs in London over the past 2–3 years – 'purposive sampling'. These AFMEs were initially contacted by telephone by MS to establish whether they would be interested in taking part in a short telephone interview using a semi-structured pro forma. If so, an appointment was made for MS to telephone at a mutually convenient time. Verbal consent was given to the interview, which was audiotaped. A semi-structured interview pro forma was used. A semi-structured interview of the independent senior forensic physician was also carried out and taped.

A telephone interview was chosen as a relatively quick, inexpensive and easy option to gain information about the trainee's experience, as opposed to a face-to-face interview or a focus group. This method had the benefit of allowing the trainee to speak confidentially, which may have been more difficult in a focus group made up of peers with a wide variation in positive and negative experiences of training.

Quality issues were addressed by returning the transcribed interviews to each of the interviewees by email for them to check accuracy of the transcript (reflecting their experience) and to allow further comments. The transcribed interviews were also sent to a peer (GN) to read and to independently look for themes – 'investigator triangulation'.[10] The themes highlighted in the AFME interviews were compared to those identified in the interview of the external assessor.

During the research an unexpected opportunity arose to interview an FME face-to-face from a constabulary outside London who had undergone a completely different training process. This was felt to be a useful opportunity to consider the experience outside London.

3. Results

The 18 PFMEs contracted to the Metropolitan Police Service (MPS) (excluding MS) were contacted and five indicated that they had no trainees in recent years. The remaining 13 Principals identified 18 doctors as possible candidates for interview.

One doctor categorically refused to be interviewed. Nine interviews were completed in the time available. The remaining doctors were not contactable in the first instance or did not return calls. The audio-taped interviews (lasting between 10 and 20 min) were transcribed by MS, including the interviews with the external assessor, and the doctor working outside London. Therefore, a total of 11 transcribed interviews were available for analysis.

The transcripts were sent to the interviewees – 10 out of the 11 responded and confirmed the content of the transcripts. The transcripts were analysed for themes and then sent to the peer (GN) for independent thematic review and comment, thus decreasing the potential for investigator bias.

4. Summary of interviews – initial training and shadowing

Eight out of the nine AFMEs interviewed had been on the Faculty/NPIA initial training course about 2–6 months before starting work. One doctor was advised at interview that attendance on the Faculty/Metropolitan Police Service development training courses and the South East and London (SEAL) course was sufficient. This doctor was not interviewed by a PFME. The doctor working outside London (OL) did not attend any theoretical training course before starting work as an FME. One of the MPS doctors, who had worked in a different constabulary, also had not attended a training course before starting to work as an FME in that constabulary. One of the London doctors felt that they did not need formal training as they were only working as a locum and did not have a regular slot on the rota.

All doctors had shadowed either the Principal in the area they were going to work in or another Principal and/or Senior FMEs. The doctor working outside London had also shadowed an FME before starting work. Four doctors were not aware of the existence of the Good Practice Guidelines for FMEs within the MPS (GPG).[11]

5. Clinical supervision

All AFMEs stated that there were experienced FMEs to assist them on the phone when they started work. However, it was not always their allocated Principal but other doctors from the group.

One Principal actually supervised the AFME in the police station observing the doctor doing an assessment. In another group the Principal had given the AFME a shift to do and was readily available to come to the police station if required. The doctor working outside London had no clinical supervision on starting working.

One doctor commented that the quality of care provided by colleagues was very variable and expressed concerns that shadowing could be inadequate as a learning experience if colleagues are not working to the same guidelines and standards.

6. Group meetings and individual PDPs

Only two AFMEs had pre-arranged meetings with their Principal to discuss their particular training needs and progress. In three other cases there was informal feedback at the end of regular group meetings. Four assistants had not met with their Principal outside a group meeting. The doctor working outside London had no meeting with the lead FME. No trainee, including the doctor working outside London, had experience of using the practical induction training guide with their Principal FME.

Eight out of nine AFMEs met regularly with their groups. The doctor working outside London had meetings with other doctors working for the local outsourced provider.

7. Appointment process

Of those who had been appointed ($n = 4$) all felt ready. The doctor working outside London did not feel ready but "was able to cope". No AFME received the 'certificate' of competence.

Three of the four appointed doctors had an interview with the external assessor. Two of these found this independent evaluation useful. The other AFME was not advised of the purpose of the interview due a breakdown in communication from police management and this had an adverse outcome on the process.

Four of the AFMEs interviewed had not completed two years induction training by January 2009, when the Metropolitan Police Service changed the contract for services with the doctors. One FME had completed two years in November 2008 but was advised not to pursue appointment due to the impending contractual changes. One FME had been appointed without an independent evaluation from the external assessor. In this case the PFME spoke to the police management team and sent a report regarding the AFME. The doctor working outside London received no independent evaluation.

8. Comments regarding how the training could have been improved

- NPIA/FFLM theoretical course was well received by all the doctors that attended the course.
- The amount and type of shadowing experience was very variable.
- It was suggested that training should be more focussed and based around the individual doctor's previous experience, taking into account their previous qualifications and competencies. Use of case-based discussions (CBD) was suggested.
- Where there were regular meetings with the other doctors in the group these provided support in various ways – social, peer support, but also discussion of difficult cases. It was recognised that doctors were working alone so needed support. The recent demise of the group structure was mentioned negatively.
- It was suggested that supervisors should spend more time discussing how to work with the police on a practical level, considering the difference in philosophy.
- Practical training should be backed up by continuing theoretical training with advice about attendance at relevant courses as part of the personal development training programme (PDP) for the individual doctor. Some of the doctors ($n = 3$) had started studying for a postgraduate qualification in clinical forensic medicine and had only then realised that there was still quite a lot to learn that should have been covered in a more formalised initial training programme.
- The requirement to be self-motivated in order to address one's own learning needs was identified. The need for a formal appraisal was recognised.
- Supervisors should be working to a similar standard and teaching AFMEs evidenced-based practice.
- Meetings with supervisors should be structured and regular – once a fortnight was suggested.
- Independent evaluation by the external doctor was felt to be a very useful, positive experience. The doctor reviewed cases notes and statements and provided feedback which was extremely helpful.

9. Summary of interview with external assessor

The external assessor had seen about 15–16 AFMEs in recent years performing a "summative assessment in a constructive way". The external assessor's interview could take over an hour and included an evaluation of the doctor's experience together with an assessment of the quality of their clinical notes and statements for courts. If, after interview, the external assessor considered that individuals were not safe to practise as independent FMEs then the conclusion was that the AFME had not finished their training and could not be "passed". Consideration was given to attitudes and the ability to assess situations "on their feet". This senior doctor felt that the interview was "trying to do something by proxy ... as there was no opportunity to see them at work".

If the external assessor did not "pass" the individual doctor a further assessment was done after a fixed period of time so that the doctor could put into practice what had been discussed.

Overall, the external assessor felt that it was not lack of knowledge that was the problem, but lack of the right support from the supervisor. The level of support offered to doctors varied enormously – from being unable to ask for help or being belittled for seeking such help at one extreme to receiving extremely close, helpful and constructive supervision at the other. The external assessor felt this difference in support and training was obvious in the end result.

The external assessor felt that training was not tailored to the individual doctors so that gaps in knowledge were not always recognised, especially if AFMEs did not come from a generalist background but were very experienced in another field, such as emergency medicine or psychiatry. The external assessor recommended that trainers should not take knowledge for granted, even where there was specialist knowledge because the application of this knowledge in the custodial environment was quite different.

The external assessor also commented on a potential conflict of interest between the PFME as the trainer/supervisor and organiser of the rota, and therefore the workload, and the trainee.

10. Discussion

This project is an example of action research where change is planned through the research process and the participants in the research are directly engaged in the process.[12] The familiarity of the interviewer (MS) with the interviewees may have introduced an element of bias due, for example, to a potential reluctance to criticise the PFME or possible concerns regarding confidentiality. The choice of a telephone interview provided a much more personal view and in-depth information than a questionnaire.[13]

However, the responses obtained have shown that the current training has no formal structure and doctors have come through the process successfully more by individual endeavour than by any auditable training process. Advisory documents are available from the FFLM but are not used; no one received the 'certificate' of competence, and only three doctors were seen by the external assessor. Four out of nine doctors had not heard of the Good Practice Guidelines (GPG) which should be sent to all new doctors, and the PFME should ensure the AFME had received the document.

An overwhelming theme emerged that there should be a more formal structure to the training of newly appointed FMEs. Even

those who found the overall experience good thought that there should be regular meetings with the supervisor, especially when first starting work, to ensure that all areas were covered. The training experience varied enormously depending on which group you were allocated to, and the enthusiasm of the PFME for supervising AFME's training, or the enthusiasm of other members of the group to provide *ad hoc* support when requested. The one doctor who did not attend an ITC was not interviewed by a PFME.

Effective supervision needs to be offered in context with supervisors aware of local policy and Faculty expectations[14]; only one PFME actually supervised the AFME in the workplace – 'direct supervision'.

11. Conclusions

This small pilot study suggests that the process of practical training in London is not fit for purpose. Although the FFLM has a draft paper recommending criteria for the selection and approval of trainers in CFM,[15] there is neither a formal approval process, nor training and accreditation for supervisors/trainers in London. It should be mandatory in this field, as in the NHS, for educational supervisors to undergo training and review of their performance.[16]

Despite conflicting time and financial pressures, a formalised structure to the training process should be established that both trainee and supervisor are fully aware of, with each trainee having a named clinical and educational supervisor during the training period. Unless recognition is given to the importance of adequate training the current unsatisfactory situation will continue.

Conflict of Interest

MS works as a consultant to G4S.

Ethical Approval

Approval for this research was obtained from the Faculty of Forensic and Legal Medicine (Academic Committee) and Commissioner of the Metropolis' Advisory panel. The Chair of the Wandsworth Research Ethics Committee (REC, St. George's) had advised that the project was a survey not requiring ethical review by a NHS REC.

Funding

None declared.

Acknowledgements

This paper is based on a research project submitted by MS for the Postgraduate Diploma in Medical Education awarded by University College London. Thanks are due to the tutors David Parry and Tina Nairn for comments during the drafting of the project proposal.

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